PLAN OPERATIONS	Advantage Dental From DentaQuest		
	Policy and Procedure		
Policy Name:	**Encounter Data Audit and Submission**	Policy ID:	**PLANCG-22**
Approved By:	Quality Assurance and Performance Improvement Committee	Last Revision Date:	08/18/2025
States:	Oregon	Last Review Date:	10/08/2025
Application:	Medicaid	Effective Date:	10/09/2025

PURPOSE

To establish Dental Care Organization's (DCO's) policy on encounter data submissions and provider auditing of encounter data submission.

POLICY

1. Encounter Data Submission
    A. Providers shall submit encounter data to the DCO on the most recent American Dental Association (ADA) Claim form, or other form as required by OHA or the DCO.
    B. Providers shall submit claims to the DCO within 30 days of the date of service (but not to exceed 120 days) to facilitate collection of encounter data and effective utilization management except in the following cases where all claims need to be submitted within 12 months of the date of service:
        1. Pregnancy
        2. Eligibility issues such as retroactive deletions or enrollments
        3. Medicare is the primary payer
        4. Other cases that delay the initial billing to the DCO
        5. Third Party Liability
    C. Providers will submit encounters for all services provided to DCO enrollees, including those with other insurance coverage.
        i. All providers must follow Coordination of Benefits and Third Party Liability rules (see TPL policy).
    D. The DCO accepts claims electronically, hard copy by mail/fax, real time through a clearinghouse, and through its secure provider portal.
        i. All hard copy claims are date-stamped, batched and logged when the claim is received and hand-entered into the DCO's claims processing system within 3 business days.
        ii. Encounter forms shall be screened to verify:
            1. Completeness of information
            2. Current ADA code for service
            3. Correct Enrollee OHP ID number
    E. The DCO has an auto-adjudication system built into its claims processing system. When claims come into the claims processing system they run through this auto-adjudication process immediately and this processor will determine if a claim analyst needs to review the claim or it will send it through for payment or denial. The auto-adjudication system results in faster payment to billing providers for clean claims.
        i. Claims are distributed to appropriate workflow buckets for correction, additional information requested, claim typing, etc.

ii. 90 percent of claims received will be processed and paid or denied within 45 days of receipt and 99 percent of claims received will be processed and paid or denied within 60 days of receipt.
    1. If the requested additional information required to process the claim is not received within 7 days, the claim will be denied and the provider will be notified via an Explanation of Benefits (EOB) with denial coding.

F. A remittance advice is processed once a week for all processed DCO claims.
    i. All complete claims that have been auto-adjudicated or manually adjudicated are processed for payment or denial and an EOB is generated to the billing provider.
        1. Adjudication of Disputed Claims: The DCO pays the portion of the clean claim that is not in dispute and notifies the provider in writing why the remaining portion of the claim will not be paid within 30 days of receipt of the claim by denying the disputed claims.
    ii. It is the responsibility of the provider to audit their encounters against the EOBs they receive.
    iii. Enrollees will receive an EOB for all denied services so that they have the right to appeal if they are being charged for services.
    iv. Claims are moved from an active status to a historical status once they are processed.
G. The Associate Director of Plan Processing has the overall responsibility of verifying encounters are submitted.
H. Once claims have been processed, encounter data files (837D) will be submitted to each CCO on a weekly basis.
I. The following information will be included on all encounter submissions:
    i. Enrollee's name
    ii. Enrollee's address
    iii. Enrollee's Date of Birth
    iv. Enrollee's OHP ID number
    v. Date(s) of Service
    vi. Place of Service Code
    vii. Procedure Code (ADA Code)
    viii. Tooth Numbers
    ix. Specific Surface Codes
    x. Billed Charges
    xi. Provider's Name
    xii. Provider's Tax ID Number (TIN)
    xiii. Provider's Address
    xiv. Provider's License
    xv. Provider's National Provider Identifier (NPI)
    xvi. All accepted liability claims submitted by DCO must contain paid amount (or reason for zero payment) and the fee for service equivalent amount, also referred to as the allowed amount.
J. The DCO will send a CVF (H2) form to each CCO by the end of the week following the file submission showing the total number of encounters and dollar amount submitted.
K. If the H2 form is out of balance with the DCO's total encounters submitted, the CCO will request for the DCO to submit an H3 form acknowledging the discrepancy. The DCO's Electronic Data Interchange (EDI) Support Department will research the rejected encounters for resubmission.
L. Pended claims are reported to the DCO from CCOs on a weekly basis. These encounters are considered pended if the billing/treating provider does not have an active DMAP number for the date of service or if the encounters were submitted with the incorrect

coding. The DCO's EDI Support Department will research the pended claims and work with the DCO's Provider Relations Department to have a 3108 form submitted to OHA for the provider or find the correct coding for the claim to process. The DCO's EDI Support Department will either fix the pended claim via OHA's Medicaid Portal website (MMIS) or submit the correction to CCO if the DCO does not have access to the CCO's MMIS account.

M. Unencountered claims are reported to the DCO from CCOs on a monthly basis. These encounters are rejected for numerous reasons including: other insurance information, retro termination from CCO, retro enrollment to another CCO, etc. The DCO's EDI Support Department will research the unencountered claims to create a new 837 file for submission within 30 days of the receipt of the unencountered claims file.

2. Encounter Data Audit
   A. The following procedure will define how encounter data will be audited by the provider's office:
      i. A claims remittance report, in the form of an explanation of benefits (EOB), will be sent with detailed encounter data information on a weekly basis. These reports will show the claims that the DCO processed that week. The report will show the enrollee's name and ID, the date of service, the amount billed, and the allowed amount.
      ii. If a provider would like to review this report electronically, it is also located on the secure provider portal under the Claims section; titled Claims Lookup. This report can be accessed by the provider using their login and password. A provider can review their encounter data on this site by the date of service on the claim or by the date the DCO processed the claim.
      iii. The encounter data credit is processed from the DCO's allowable fees for the procedures that have been done as allowed under the enrollee's benefit package.
      iv. It is important that the claims data submitted to the DCO matches the enrollee's chart.
      v. If an EOB shows a discrepancy, the provider will need to re-bill any claims that should have been received and notify the DCO of the erroneous billing.

DEFINTIONS

"**Encounter Data**" is information submitted to the DCO by providers that documents both the clinical conditions they diagnose as well as the services and items delivered to OHP enrollees.

REFERENCES
OAR 410-141-3570 Managed Care Entity Encounter Claims Data Reporting

FORMS AND OTHER RELATED DOCUMENTS (by name, if applicable)
ADA Dental Claim Form Completion Instructions

Revision History

Date:	Description
03/12/2018	Approval and adoption.
02/16/2019	Updates based on CCO partner audit findings.

04/23/2019	Updates based on annual review.
12/05/2019	Conversion to revised policy and procedure format and naming convention.
12/09/2020	Updates based on annual review.
5/18/2021	Updates based on CCO partner audit findings.
10/13/2021	Updates based on annual review.
12/31/2022	Updates based on annual review.
11/13/2023	Updates based on annual review.
03/28/2024	Updates based on annual review.
01/09/2025	Updates based on annual review.
08/18/2025	Updates based on CCO audit findings.